South Coast PSYCHIATRY

Psychotherapy & Medication Management

INSURANCE INFORMATION

* *insurance information is needed in case a medication requires a prior authorization**

Patient's Name: _____
(First) (MI) (Last)

Patient's Birth Date:_____/_____/_____ Patient's Gender: Male _ Female _

Patient's Status: Single _ Married _ Other _ Employed _ Full-time student _ Other _
(check all that apply)

(Please Note: "Policy Holder" refers to the name of the person who holds the insurance plan)

Patient's relationship to the policy holder: Self __ Spouse _ Child _ Other: _____

Policy Holder Name: _____
(First) (Last)

Policy Holder's Birth Date:_____/_____/_____

Name of Insurance Company: _____

Policy ID #:_____Policy SS#: _____

Group #:_____Policy Holder's Employer: _____

Name or Type of Plan: PPO _ Indemnity _ HMO _ EAP ___Other: _____

Phone number for verification of benefits/eligibility (on back of card): (_____)_____

PHARMACY INFORMATION

*Name of Pharmacy:*_____ *Pharmacy Telephone #:*_____

*Address of Pharmacy:*_____ *Pharmacy Fax #:*_____